DEPARTMENT OF HEALTH AND [illegible]AN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445017	A. BUILDING _____ B. WING _____	06/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY PLACE AT MARYVILLE	2648 SEVIERVILLE RD MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual recertification survey was completed at Asbury place at Maryville on May 31-June 2, 2011. Deficiencies were cited under 42 CFR 483, Requirements for Long Term Care Facilities.	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, policy review, and interview, the facility failed to obtain a physician's order and informed consent for restraint use for one resident (#18) of twenty-five residents reviewed. The findings included: Resident #18 was admitted to the facility on May 22, 2009, with diagnoses including Dementia with Lewy Bodies, Depressive Disorder, and Paralysis Agitans. Medical record review of the Minimum Data Set (MDS) dated March 28, 2011, revealed a physical restraint was used daily in a chair. Medical record review of the Restraint Evaluation Form dated February 28, 2011, and March 29, 2011, revealed the resident was being physically restrained when in the wheelchair.	F 221	F 221 – Resident # 18 has been assessed by the physician. An order for the use of the lap belt has been determined to be the least restrictive device, and an order has been obtained. Informed consent has been obtained by the resident's Power of Attorney. All other residents using restraints have been identified, assessed and determined to be using the least restrictive restraint. The medical records for all residents using restraints have been reviewed, and all contain a current physician's order for the use of the restraint, as well as informed consents signed by each resident's Power of Attorney.	7/15/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lisa Brown — TITLE: Administrator — (X6) DATE: 6/30/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221	Continued From page 1 Medical record review of the February 2011, May 2011, and June 2011, Physician's Recapitulation Orders and Telephone Orders dated February 1, 2011, through June 2, 2011, revealed no order for a physical restraint. Medical record review revealed no signed informed consent for the use of the physical restraint. Review of the facility's "Restraints-Physical" policy revealed, "...In all cases, a physician's order is necessary for the use of a physical restraint. The order must detail the type of restraint, when it is to be used, and for what reason it is to be used...In all cases, the use of the restraining device must first be explained to the resident, family member, or legal representative and used only after their approval..." Observation on June 1, 2011, at 12:45 p.m., and 3:00 p.m., and on June 2, 2011, at 9:00 a.m., and 1:00 p.m., in the resident's room, revealed the resident on the bed and the resident's wheelchair with a lap belt restraint in the seat of the wheelchair, setting at the resident's bedside. Interview with Licensed Practical Nurse #3 on June 1, 2011, at 3:25 p.m., at the 2-North Nurse's Station, confirmed the resident is transferred from the bed and placed in the wheelchair daily. Continued interview confirmed the resident is physically restrained with a lap belt when in the wheelchair. Further interview confirmed the lap belt is attached and secured onto the kick spurs of the wheelchair and the resident cannot self-release the lap belt. Continued interview confirmed a physician's order and informed	F 221	The Restraint policy has been reviewed and revised. The DON or designee has re-educated the Nursing staff on the Restraint policy – including the need for physician orders and informed consents. The DON or designee will audit the Medical Records of 10 residents per week for 4 weeks, then 10 residents per month for 3 months for appropriate restraint orders and informed consents. The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting monthly for three (3) months and recommendations made as appropriate.	

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F 221	Continued From page 2 consent for the lap belt had not been obtained. Interview with the Director of Nursing (DON) on June 2, 2011, at 1:30 p.m., in the Conference Room, confirmed the resident is physically restrained with a lap belt when in the wheelchair. Further interview confirmed the lap belt is attached and secured onto the kick spurs of the wheelchair and the resident cannot self-release the lap belt. Continued interview confirmed the lap belt is used as a physical restraint for this resident and the facility failed to obtain a physician's order and informed consent to use the lap belt.	F 221		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to provide an environment conducive to the accommodation of resident needs for two (#17, #25) of twenty-five residents reviewed. Resident #17 was admitted to the facility on July	F 246	F – 246 – The call lights for Resident # 17 and Resident # 25 have been placed in an accessible location. All residents using call lights have been assessed to ensure that call lights are currently placed in an accessible position. All residents unable to use call lights have been identified and appropriate device has been placed. Call light policy has been reviewed and revised.	7/15/11

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F 246	Continued From page 3 17, 2009, with diagnoses including Hydrocephalus, Dementia Secondary to Brain Injury, Bipolar Disorder, Anxiety Disorder, and Mental Retardation. Medical record review of the Minimum Data Set dated March 30, 2011 revealed the resident is severely cognitively impaired, the resident is bed or chair bound and dependent on staff for all activities of daily living. Observation of the resident on May 31, 2011, at 9:10 a.m., revealed the resident in the bed and the resident's call light was on the floor under the bed and not accessible to the resident. Interview with LPN #2, on May 31, 2011 at 9:20 a.m. confirmed the resident could use the call light, but the resident could not access the call light from the floor to call for assist if needed. Resident #25 was admitted to the facility on March 26, 2009, with diagnoses including Hypertension, Diabetes, Congestive Heart Failure and Glaucoma. Medical record review of the Minimum Data Set dated April 26, 2011, revealed the resident is severely cognitively impaired and dependent on staff for assistance with all activities of daily living. Medical record review of the facility's care plan dated February 17, 2011, revealed " ... impairment in ADL functioning ability:...needs extensive assistance with activities of daily living. Continued care plan review revealed the resident was at an increased risk for falls...had a history of falls..." The care plan interventions included	F 246	Nursing staff have been re-educated on the placement of resident call lights and the call light policy by the DON or designee. Observation audits of resident call light placement will be completed by the DON or designee for 20 residents per week for 4 weeks then 20 residents per month for 3 months. The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting monthly for three (3) months and recommendations made as appropriate	

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F 246	Continued From page 4 "...Call light placed within reach of resident...remind resident to call for assist as needed...answer call light promptly." Observation of the resident on May 31, 2011, at 9:25 a.m., revealed the resident in the bed, with head of bed elevated 90 degrees. The resident was slumped to the left side and stated that she was uncomfortable and needed assistance. The resident's call light was across the room and not accessible to the resident in bed. Interview with CNA #3 on May 31, 2011, at 9:28 a.m. in the resident's room, confirmed the resident could not access the call light for staff assistance if needed. Interview with the Administrator on June 1, 2011, at 8:50 a.m., in the resident's room, confirmed the resident was unable to access the call light from the floor.	F 246		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279	F – 279 – Resident # 5 has been assessed by the physical therapist for the most appropriate transfer method. The care plan has been reviewed and revised to reflect the use of the mechanical lift for all transfer. Resident # 5 is currently being transferred using the mechanical lift.	7/15/11

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F 279	Continued From page 5 psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to follow the care plan, for one (#5) resident of twenty five residents reviewed. The findings included: Resident #5 was admitted to the facility on January 1, 2007, with diagnoses including Dementia, Parkinson's Disease, and Functional Quadriplegia. Medical record review of the Minimum Data Set dated April 26, 2011, indicated the resident was totally dependent on staff for all activities of daily living, toileting needs, and transfers. Medical record review of the care plan dated April 29, 2009, revealed "...At risk for falls related to severely impaired cognition/safety awareness ...unable to ambulate and Osteoporosis." Continued review of the current care plan revealed "...use (named mechanical) total body lift for transfers". Review of facility documentation dated January 10, 2011 revealed Certified Nurse Assistant (CNA) #2 stated CNA #4 transferred the resident from the chair to the bed, in the resident's room,	F 279	All residents using a mechanical lift for transfers have been identified and screened by Therapy to assess the most appropriate transfer method. The care plans and Kardex for these residents have been reviewed and reflect the current method of transfer. Nursing staff have been re-educated by the DON or designee on addressing transfers on the resident care plan / Kardex, as well as the use of the mechanical lift. The DON or designee will audit the care plans of 10 residents per week for 4 weeks, then 10 residents per month for 3 months to determine that the care plan matches actual transfer practice.	

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F 279	Continued From page 6 on January 4, 2011 without the aid of the total body lift. Interview with the Clinical Staff and Training Coordinator (CSTC), June 2, 2011, at 10:20 a.m., in the 2 North dayroom confirmed CNA #4 transferred the resident from the chair to the bed, in the resident's room, on January 4, 2011 without the aid of the total body lift. Interview with the Administrator on June 2, 2011, at 11:05 a.m., in the conference room, confirmed the resident's care plan was not followed when CNA #4 transferred the resident from the chair to the bed, in the resident's room, on January 4, 2011 without the aid of the total body lift.	F 279	The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting monthly for three (3) months and recommendations made as appropriate	
F 283 SS=D	483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to complete a nursing discharge summary for one discharged resident (#23 - closed record) of three discharged residents (closed records) reviewed. The findings included:	F 283	F – 283 – The nursing discharge summary for Resident # 23 has been completed to reflect the Resident's status at the time of discharge. The medical records of residents discharged in the previous three months have been reviewed. Discharge summaries are in place for all residents.	7/15/11

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F 283	Continued From page 7 Resident #23 was admitted to the facility May 6, 2011, with diagnoses including Peripheral Vascular Disease, Right Great Toe Amputation, Congestive Heart Failure, Pneumonia, Hypertension, Anemia, Acute Renal Failure, Chronic Kidney Disease, Diabetes Mellitus, Type II and Epilepsy. Medical record review revealed the resident was discharged home with family on May 17, 2011, and no nursing discharge summary was completed. Interview with the Director of Nursing, in the conference room, on June 2, 2011, at 2:30 p.m., confirmed no nursing discharge summary was completed.	F 283	Licensed nurses have been re-educated by the DON or designee on the discharge process, including completion of the discharge summary. The Medical Records Clerk or designee will audit the discharge records of all resident discharges for 4 months for presence of a completed discharge summary. The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting monthly for three (3) months and recommendations made as appropriate	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility provided documentation, observation, and interview, the facility failed to ensure safety devices were functioning and in place to prevent a fall with injury (harm) for one (#3) resident., and failed to ensure safety devices were in place to	F 323		

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F 323	Continued From page 8 prevent falls for one (#6) of twenty-five residents reviewed. The findings included: Resident #3 was admitted to the facility on July 29, 2010, with diagnoses including Alzheimer's Dementia, Osteoarthritis, Fractured Fibula and Tibia (bones in the leg), and Osteoporosis. Medical record review of the Minimum Data Set (MDS) dated November 9, 2010, revealed resident #3 had impaired short and long term memory, moderate difficulty with decision making, had a history of falls, and required assistance with all activities of daily living including transfers. Medical record review of the resident's current care plan updated on November 10, 2010, December 8, 2010, and January 5, 2011, revealed "...deficits in memory, decision making, communication and judgement R/T (related to) Alzheimer's Dementia...Personal alarm: bed chair 11-10-10 Pressure sensor: bed..." Medical record review of the nurse's notes dated August 18, 2010, to November 10, 2010, revealed the resident had several falls without injury. Medical record review of the nurse's notes dated November 24, 2010, revealed "...found sitting in floor beside bed. Res(resident) had removed personal alarm and bed sensor did not alarm. No injuries found..."	F 323	F 323 – Resident # 3 has been screened by Therapy and assessed for the most appropriate alarm. Resident # 6 has been screened by Therapy and assessed for the most appropriate alarm. The care plans for Resident # 3 and Resident # 6 have been updated to reflect current alarm usage. All residents using alarms have been identified, assessed and determined to be utilizing the most appropriate alarms. The care plans for residents using alarms have been reviewed and revised as needed to reflect the residents current alarm usage. The Falls Management policy has been reviewed and revised. Nursing staff have been re-educated on the use of alarms by the DON or designee.	7/15/11

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F 323	Continued From page 9 Review of the facility documentation dated November 24, 2010, revealed "...resident removed personal alarm & sensor did not sound. Therapy to screen... Interventions; (no interventions were marked). See interdisciplinary note..." Medical record review of the Therapy Screen dated December 1, 2010, revealed "...Reminded resident to push call button. Pt does have confusion..." No documentation was found if the function of the alarms was assessed to improve the resident's safety. Review of the facility documentation dated December 4, 2010, revealed resident #3 "...was lying on the floor next to the bed...Personal alarm hx (history) of taking it off...found in bed unattached to resident...Pressure sensor (pad in the bed that sounds when resident attempts to get out of the bed) on- did not activate until CNA (Certified Nurse Assistant) pushed it to see why it didn't work...Level of Consciousness A (alert) & OX1 (oriented to one {self})" Continued review revealed no documentation the function of the alarms was assessed to improve the resident's safety. Medical record review of a nurse's note dated December 6, 2010, revealed "...resident in hospital (transfered to the hospital on December 5, 2010)...X-ray results Fx (fracture) R (right) femur (long bone in the leg connected to the hip)..." Review of the Falls Interdisciplinary Team	F 323	The DON or designee will observe and audit 20 residents using alarms weekly for 4 weeks, then 20 residents monthly for 3 months to determine appropriateness, placement and functionality. The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting monthly for three (3) months and recommendations made as appropriate	

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F 323	Continued From page 10 Narrative Note dated December 6, 2010, revealed "...Resident curently in hospital. Screen completed prior to hospitalization with poor safety awareness..." Medical record review of the resident's careplan revealed the resident was re-admitted on December 8, 2010, and no new interventions for safety were put in place upon re-admission. Review of the facility provided documentation dated January 8, 2011, revealed "...Res found in floor @ (at) FOB (foot of bed)...Personal alarm removed by pt & cord wound up &(and) set on bedside table ..." Continued review revealed no documentation the use of the alarms was assessed to improve the resident's safety. Observation on June 1, 2011, at 1:30 p.m., in the dining room revealed the resident in the wheel chair with the personal alarm attached to the sweater and the control box in a bag on the back of resident's wheel chair (wc). Continued observation revealed resident #3 heard a beeping noise, reached into the bag on the back of the wheel chair removed the control box, checked if the tab was still attached to the box, and returned it to the bag. Observation and interview on June 2, 2011, at 1:40 p.m., near the 1 South nurse's desk with Licensed Practical Nurse (LPN) #1, CNA #1 and CNA #2, revealed the resident in the wheel chair without the personal alarm attached to the resident. Continued observation revealed LPN #1 searched the resident's bag on the back of the	F 323		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 11 wheel chair, and the bag contained the personal alarm with the string wrapped around the control box. Continued observation revealed CNA #1 and CNA #2 re-attached the personal alarm to the resident and put the control box into the bag on the back of the resident's wheel chair. Interview with LPN #1, CNA #1, and CNA #2 all confirmed resident #3's personal alarm was not attached to the resident to alert staff of unsafe attempts to transfer self. Interview on June 2, 2011, at 1:05 p.m., in the facility conference room with the Director of Nursing (DON) confirmed the resident removed the personal alarm and the bed sensor alarm did not sound on November 24, 2010, resulting in the resident falling with no injury. Continued interview confirmed the resident again removed the personal alarm and the bed sensor did not sound on December 4, 2010, the resident fell fracturing the right femur resulting in harm. Continued interview revealed the DON could not find any documentation the functioning of the alarms, and the positioning of the alarms, was assessed to provide safety for the resident until the January 8, 2011, fall. Resident # 6 was admitted to the facility on November 11, 2010, with diagnoses including Malaise, Fatigue, Adult Failure to Thrive, Bell's Palsy, and Psychosis. Medical record review of a Fall Risk Assessment and the care plan dated November 12, 2010, revealed "... Increased risk for falls related to weakness, psychotropic medications, tremors and rigidity associated with Parkinson's Disease, unaware of safety issues, forgetful, and leans	F 323		

DEPARTMENT OF HEALTH AND I AN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445017	A. BUILDING _____ B. WING _____	06/02/2011

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F 323	Continued From page 12 forward in wc with history of falls." Continued review of the care plan revealed the resident required assistance of one, with transfers, positioning, ambulation and toileting. The resident also required a personal safety alarm (psa) while in the chair and in the bed. Medical record review of a nurse's note dated May 6, 2011, as a late entry regarding a May 4, 2011, "...resident found sitting on floor in front of w/c no apparent injuries ..." Continued medical record review of facility provided documentation dated May 4, 2011, revealed "...resident found sitting on floor in front of wc... personal alarm found on top of night stand...not on resident." Interview with the Assistant Director of Nursing on June 1, 2011, at 2:04 p.m., at the 2 South Nurse's Station, confirmed the resident had fallen forward, out of the wheelchair, and the psa was not on the resident as ordered, to alert the staff of unassisted transfers.	F 323		
F 372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policies and procedures, and interview, the facility failed to dispose of garbage and refuse properly. The finding included:	F 372	F372 – Dumpster #1 has been replaced. The dumpster doors have been closed securely and the dumpster area cleaned.	7/15/11

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F 372	Continued From page 13 Observation of the dumpster refuse area with the Executive Chef on May 31, 2011, at 9:45 a.m., revealed the following: 1. A side door was fully opened on one (dumpster #1) of four dumpsters. 2. A side door was half-way opened on one (dumpster #2) of four dumpsters. 3. Liquid refuse leaking from dumpster #1, ran onto and accumulated on top of the concrete slab where the four dumpsters were positioned. The dumpster refuse and surrounding area produced a strong, foul, and soured odor. 4. Trash and refuse on the ground surrounding two of four dumpsters, included: disposable latex gloves, empty condiment containers, an empty facial tissue box, scattered pieces of paper, and a milk container. Review of a facility policy and procedure titled "Garbage and Trash Disposal" revealed, "...Poor garbage and trash storage and disposal can lead to other types of problems. Various types of vermin will be attracted to the unit because of poor refuse storage on the outer premises. The vermin can enter and then cause further problems once inside...3. Using dumpsters for refuse disposal. The lids to these should be kept closed and waste should be in tight-closing, sealed, plastic bags. It will reduce odors and keep the dumpster clean..." Interview with the Executive Chef on May 31, 2011, at 9:50 a.m., at the dumpster refuse area,	F 372	The policy on Garbage and Trash Disposal has been reviewed and revised to include routine monitoring and cleaning. The dining closing check list has been updated to include a daily dumpster check to assure all doors are closed and area is clean. The Dining Director or designee has re-educated staff using the dumpster area on current policy regarding dumpster area maintenance. The dumpster area will be monitored and audited daily for 4 weeks then monthly for 3 months for cleanliness and securely closed doors.	

PRINTED: 08/10/2011
FORM APPROVED
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F 372	Continued From page 14 confirmed the facility failed to ensure the proper disposal of garbage and refuse.	F 372	The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting monthly for three (3) months and recommendations made as appropriate.	